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ABSTRACT

This paper reviews in detail the history and current status of the World Federation for Mental Health (WFMH), since its beginning in 1934, as the only world-wide, voluntary, non-governmental, interdisciplinary, mental health coalition comprised of both volunteer and professional organizations as well as individual members. The relationship of the WFMH to other world health and mental health organizations is presented along with a discussion of its twin goals of education in the area of mental health, and advocacy for the rights and welfare of the mentally ill and their families. The activities and plans of the WFMH for bringing about the optimal functioning of such vulnerable populations as minorities, migrants and refugees, the elderly, victims of violence, and mothers and infants are also discussed. Differences between the positive mental health goals of this voluntary, nongovernmental organization and intergovernmental agencies are highlighted with particular reference to community responsibility, professionalism, and the centralization of authority. (Author/JAC)

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MENTAL HEALTH: MORE THAN THE ABSENCE OF ILLNESS[1]

Eugene B. Brody, M. D.[2]

I am delighted to be with APA's international committee representing a voluntary association committed to fostering mental health and reducing its impairment. The worldwide movement, stemming from Clifford Beers' 1908 book, "A Mind That Found Itself," began with the United States National Committee for Mental Hygiene. "Hygiene" was a prophylactic term. It referred to the prevention of mental illness, less in its primary sense than that of shortening episodes, improving rehabilitation, and reducing the likelihood of recurrence. The movement has a major concern with the welfare of the mentally ill and their families. Originally this focused on their conditions of hospitalization and treatment. In recent years it has come to include their civil rights as well as the rights of so-called "consumers" of mental illness services in general.

My original concerns were also with mental illness. Forty years ago, as a medical student, I took my clerkship at the Boston Psychopathic Hospital. But a few years later I was shaken when that

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institution underwent what seemed at first a semantic metamorphosis, emerging as the Massachusetts Mental Health Center. It was a bellwether. As the trend to relabelling accelerated throughout the country, musty state hospitals were redesignated wholesale as mental health centers and institutes. These developments followed the passage of the National Mental Health Act of 1946 and the founding shortly thereafter of the National Institute of Mental Health. After President John F. Kennedy's Community Mental Health program of 1963, nearly a generation later, it was almost impossible for a while to find any reference to mental illness in the government literature. Mental health had become institutionalized as a concept, and institutionalized ideas acquire a momentum and political power of their own. This is especially true for such connotatively freighted ideas as "health" which includes elements of happiness, wholesomeness, soundness, and well-being as well as the absence of disease. "Health" is uniquely useful as a multi-purpose symbol. WHO, the United Nations' World Health Organization, in fact, uses the entire historical-cultural mix in its definition of health, as "mental, physical and social well-being."

I used to think, naively, that illness was more easily defined than health. Recent research has even added new evidence of iden-

tifiable neurochemical and genetic configurations behind some familiar behavioral syndromes. Yet, in the industrialized nations, it seems more difficult than ever to arrive at a public consensus about mental illness. This is because of the attention focused by the concept of mental health, as well as by social scientists, on the context of behavior. Within that context man is seen as having an immense range of behavioral options; even idiosyncratic behavior aimed at changing context can be understood as coping or expressing legitimate strivings for self-determination.

The post World War II climate also fostered self-awareness and collective efforts at self-realization by formerly passive minorities. The mentally ill, along with such groups as the aged and the physically handicapped began to be understood as minorities in the sense of their lack of access to societal power. Some observers began to view the systematic psychiatric labelling of deviance--a first step toward hospital detention or behavioral change--as a potential threat to individual autonomy and freedom.

WFMH was also founded at the beginning of this era. The just fledged United Nations Educational Social and Cultural Organization, UNESCO, asked for an international, interdisciplinary, non-governmental and voluntary organization which, free from the dictates

and constraints of national policy--and presumably sensitive to the world's range of social and cultural contexts--could consult on mental health issues to the UN and all of its agencies. This recommendation was taken up by the Interprofessional Preparatory Commission for the Third International Congress on Mental Health scheduled for London in 1948. The Commission, itself, was a multicultural creation growing from the work of 351 discussion groups, in 21 different countries, including approximately 4100 men and women representing 28 different mental health relevant disciplines. They were organized by Dr. John Rees, former senior psychiatrist for the British Army at Home in World War II. He acted for the British National Association for Mental Health which in turn acted for the International Committee for Mental Hygiene, an outgrowth of the U.S. Committee about which more in a moment.

In 1948, at the World Mental Health Congress, the new Federation was founded and for the past 34 years it has been the only nongovernmental, global mental health coalition, including both mental health professionals and the world's voluntary mental health associations. One of its first acts in 1949 was to support the establishment of a Mental Health Section in the still-infant World Health Organization. Since then, it has done its work through regional

seminars, biennial world congresses, publications, and individual consultation and advocacy when asked. In many ways its major function has been health education for professionals and policy makers, as well as the general public. Since the mid-1950's, as the only NGO with official consulting status in mental health to the various UN agencies, it has maintained volunteer representatives at UN New York, Paris, Vienna and Geneva. Our UN connection has been a highly valued source of opportunity and we devote significant effort to keeping it viable. WFMH, almost alone, was responsible for inserting a reference to mental health in the declaration emerging from the WHO/UNICEF sponsorted Conference on Primary Health Care of 1978 at Alma-Ata. The 1979 World Mental Health Congress in Salzburg was followed by a day-long examination with active UNESCO participation of mental health possibilities for UNESCO programs. As recently as two years ago, a WHO official said that if WFMH did not exist it would have to be invented; and last year in October, 1981, we were invited for the first time to send a participating observer to the WHO-MENTAL Health Section's mid-term planning meeting in New Delhi.

At the same time the various UN agencies have their own agendae which reflect the needs and compromises of governments

interacting with each other. Any NGO, therefore, must understand that the UN is not easily amenable to outside influence. The UN's Population Division, for example, is very cautious about admitting NGOs to active participation to its current project. This follows its sense that the human rights emphasis from NGO's meeting at the time of the 1974 UN World Population Conference was not totally congruent with its own needs and aims.

These realities make it necessary for us to think about how, as an NGO, we might be useful in a way which reflects our separation from the intergovernmental system. This does not mean that we need to act in opposition to it. It does mean, though, that we should work for our independent as well as affiliated interests. The World Health Organization, for example, refers to "mental, physical and social well-being" in its officially labelled search for "health for all by the year 2000." We concur with this and applaud its new interest in psychosocial aspects of health including indigenous healing systems. The major long-term project of its Mental Health Section, however, an effort to establish an international diagnostic scheme, has been a matter of concern to some non-Western observers, including psychiatrists who believe that its concepts arising in nuclear familied, industrial, literate societies are not equally applicable to

other societies and cultures. I see no evidence that this effort to establish a universal, culture-free nosology--particularly for the syndromes called schizophrenia--could pose a threat to personal autonomy or opportunity for care in some parts of the world; in fact, WHO reports of differences in the course and outcome of psychotic illness according to cultural setting belie this. ——————→ At the same time, it is the kind of concern that requires us, as a citizens' organization, to think carefully before adopting the conclusions of the WHO biomedical establishment as a basis for our own health rather than illness-oriented programs.

We did not, of course, spring full blown from the brow of the UN. Clifford Beers was an energetic, expansive man when he wasn't severely depressed. While his major focus was on the welfare of the mentally ill, his interest in their families, in the potentially ill, in adequate public facilities, and in public attitudes required the community in the long run to be the chief object of his attention. He envisioned his mental hygiene movement as applicable beyond the boundaries of a single country. This led to the very first International Congress on Mental Health called by the U.S. National Committee for Mental Hygiene. A new phenomenon in human history, it drew the astonishing number of 4,000 people to Washington, D.C. in 1930,

under the Honorary Chairmanship of President Herbert Hoover. It was here that the International Committee for Mental Hygiene was organized. The Committee held the Second International Congress in Paris in 1937, and after interruption by World War II, the Third in London in 1948.

This brief history indicates the diversity of interests combining in WFMH after the war under the single banner of mental Health. They also included a rarely mentioned, idealistic component, expressed in a Report of the Preparatory Commission for the Third International Congress in 1948. This Report was entitled, "Mental Health and World Citizenship." It suggested the emblematic significance of a global mental health coalition, which must be concerned not only with respecting the dignity of individual persons but understanding their similarities as human beings and their dependence upon the social contexts in which they live and relate to one another. Mental health was a rallying cry, then, for person-to-person contact across political and cultural boundaries and for allegiance to some universal set of ideals. These ideals are, in many respects, embodied in today's concern with universal human rights. This issue is one which the Federation has not fully met. Our Board--spread thinly across the world and representing a range

of social opinion--debated and passed, as have many other associations, a Resolution Opposing Nuclear War. The final wording and disposition of this Resolution have not been completed. The Board did issue, in 1974, a little noticed Resolution condemning the use of mental hospitals to stifle political dissenters. It still awaits a full discussion of the implications of the requests for symbolic support which have come to us from organizations such as Amnesty International and others concerned with more specific violations of human rights involving, for example, the political oppression of psychologists and psychiatrists. However, we have a Committee on Victims of Violence which, led by Susan Salasin of your organization, and supported by NIMH and the Princeton University School of Foreign Affairs, has had several meetings and is conducting survey research. Beginning with victims of crime it is considering whether or not to focus significant attention on victims of political oppression. A workshop for our 1983 World Congress here in Washington, D.C. with the tentative title, "Victims of Political Oppression: A Mental Health Issue?", is now being discussed.

The current usage of "mental health" varies. Within the United States its meaning in the last generation has been dominated by the Community Mental Health program which has waxed and waned since its inception in 1963.

Two aspects of the ideology of this program seem fundamental to today's topic. One is its legally mandated community participation in the governance of any federally funded center. This directly confronts the issues of paternalism and elitism in the relations of professionals to the citizenry at large. Whose knowledge is most crucial to health-relevant decision making--that of citizen or professional? Which group writes the rules upon which the unspoken social contract between help-seeker and help-giver is based? How does one deal with the clinical ethnocentrism of professionals? The impact of the long process of professional socialization--as well as the age, gender, ethnic and social class status of individual clinicians--is seen, for example, in how clinicians interpret the concept of "compliance" in relation to patients whose status differs from their own. Professional psychologists and psychiatrists, even social workers, may forget that the presumably "objective" standards which they apply to others reflect in part their own internalized social norms. One is reminded in this respect of John Rawls' prescription for social policy making--that it should be done behind a "veil of ignorance" so that the decision-makers will not know their own position in the society for which they make the policy.

The traditional citizen-based source of protection, of service

provision and advocacy for the mentally ill has been the voluntary mental health association. The voluntary association does not exist, however, in many of the world's countries and is present only in rudimentary form in most areas of Africa, the Middle East and even Latin America. And in these last, when an association does arise it tends to be dominated by professionals, mainly psychiatrists--one reason why WFMH must include professional as well as citizen associations, recognizing that the former as well as the latter are, in the generic sense, voluntary. The mandated community boards for U.S. mental health centers represent a relatively recent attempt to deal with the problem of citizen representation. A still newer development in North America and Europe is the development of self-help groups. Sometimes dominated by ex-mental hospital patients organizations they are beginning to threaten the voluntary mental health movement's claim to represent the consumer in this area.

The World Federation for Mental Health takes these issues seriously. One of its basic tenets is that mental health is not the exclusive province of government or the professions, but must be a concern of the citizenry at large. Just this past month, July, 1982, in London, under the leadership of our recent European Vice-President,

Mrs. Edith Morgan, a social worker, we held a Regional Seminar on collaboration between volunteers and professionals with special reference to those representing government health services. Co-sponsored by WHO, the International Hospital Federation and MIND, the UK Mental Health Association, it included 50 representatives from many European countries, Canada and the United States--among the last Dr. Gary Vanden Bos, Deputy Director of this Association. An active participant was a leader of the U.S. ex-patients' movement, whose travel and participation in the Seminar were collectively financed by the American Psychological and Psychiatric Associations and the U.S. National Mental Health Association. Several leaders of European self-help groups were also present.

Mental health associations, of course, do include many professionals, who as volunteers are freed to act as citizens in ways not possible when they represent, for example, their institutional employers or their professional trade unions. WFMH is in a unique position as the only such association which, in addition to individual members, accepts professional as well as voluntary associations and can, therefore, act as a linking mechanism--a bridge between these two groups. Our inclusion of self-help and ex-patient leaders in the London Conference marks, I think, real growth in this respect and an extension

of our usefulness as a linking organization.

The second ideological prescription of the U.S. community mental health movement, relevant to today's topic, was enunciated by President Kennedy in his initial message. In the area of mental illness and retardation, he said, "an ounce of prevention is worth a pound of cure...Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare, and education programs...". The mental health center law mandated educational and consultative services aimed at mental illness prevention. A familiar concern about prevention raised especially at our London seminar by ex-patient and self-help representatives focuses on who makes the rules--who defines deviance and how to deal with it. Mental health consultation is often to agencies with a social control function. Courts and prisons are obvious. Schools are more problematic, as are welfare departments dealing with deprived areas. The general issue is that raised by Nicholas Kittrie under the rubric of "the therapeutic state." As health depends upon the everyday social circumstances which foster or impair optimal growth, development and adult functioning, it brings these circumstances under the scrutiny and potential control of the health professional. Variations from a

behavioral norm determined by him or his employer may be classified as dysfunction or illness and dealt with accordingly. An environment defined as pathogenic becomes potentially subject to behavioral and social technologies, some of which may be subtly coercive as they implant new goals or desires in populations "at risk" for one form of deviance or another.

These considerations remind us that, while mental health has become as American as apple pie, it is, in fact, a sensitive topic. I do not share the extreme concern which has led some to label all mental health professionals as social control agents; I fear that it has deprived many disabled people of needed protection. I am unambiguously in favor of increasing the availability of services, such as those necessary for family planning, which can increase personal autonomy and mastery of one's own body. At the same time, I know that the availability of these services can be presented in a way which is coercive. Further, I do not think it possible to deny the importance for diagnosis, treatment, or health maintenance of how, within particular social settings, deviance is labelled, managed or punished, and how function is supported and conformity rewarded. The possibility of unwitting support for the social control of populations is especially great when such populations are socio-economically deprived, ethnically

different from the dominant society's decision-makers, unmotivated to work, or, possible participants in social protest movements. Accusations of political or commercial manipulation can even be levelled at concern with such health related issues as housing, employment, civil liberties and the dangers of smoking.

How much can an organization such as WFMH do outside the realm of mental illness without the risk of co-optation by social control agencies? And to what degree can it become identified with broad mental health-related causes, such as those just mentioned, without losing some of its credibility and leverage as an advocate for the mentally ill? My own feeling is that these hazards can be avoided in part by maintaining our cross-cultural viewpoint; by keeping the interests of the least advantaged members of any society in mind as we recommend policy; and by a clear independence from government and intergovernmental agencies. Our aim is to be a consultant, an advocate, not an affiliate.

In our efforts to steer a course between institutional and community concerns our work has often reflected the current concerns of the UN community, while taking up issues which it finds too politically sensitive for direct action. In 1979, for example, the UN International Year of the Child, contributed the theme of children and

families for our World Mental Health Congress in Salzburg. It was appropriate, there, for us to have a symposium on responsible reproductive behavior aimed at giving infants and children an optimal chance at development. From that symposium there emerged a Resolution on the Prevention of Unwanted Children which was adopted by the WFMH Board. This Resolution was adopted early this year by International Planned Parenthood's European Division as the model declaration for its current project on Family Planning and Human Rights.

The WFMH interest in family formation and responsible parenthood is reflected in other ways. The Zambia Mental Health Association, for example, was encouraged after its report at our 1981 World Congress in Manila to continue including family planning among its services. In 1981 at the meeting of the Inter-American Society of Psychology in Santo Domingo, WFMH co-sponsored wtih WHO-PAHO, a workshop heavily attended by nurses and midwives on social and cultural factors relevant to personal fertility regulation in the Americas. Just this last month, at the Congress of Child Psychiatry and Allied Professions in Dublin, we recognized the mental health aspects of the neonatal intensive care unit in a WFMH sponsored symposium on "Teen-Age Pregnancy and Preterm Infants."

WFMH's interest in related issues has a long history beginning with its 1952 conference on "Mental Health and Infant Development," held in England with support from WHO's European Region, UNESCO, and the United States Public Health Service. A corollary interest began with the 1953 UNESCO publication, "Cultural Patterns and Technical Change," edited by Margaret Mead, one of our former Presidents, under contract with WFMH.

Aging is another area of UN interest receiving increased attention from the Federation. In 1981 our WFMH European Region with joint sponsorship from the International Hospital Federation and the Finnish Association for Mental Health, operated a seminar in Helsinki on old age and mental health in industrialized countries, aimed mainly at health planners and behavioral scientists. This March, 1982, Gary Vanden Bos organized our position paper and led our WFMH delegation to the preforum of the World Assembly on Aging in Vienna. Our ideas as the mental health NGO will be taken into account, but actual participatory time for NGOs at the Assembly on Aging proper, held in Vienna early this month was limited. This regularly encountered problem of NGOs in UN consultative status, may reflect the fact that they come almost exclusively from the West and are to some degree uncertain entities in the eyes of the Third

World representatives who make up the bulk of UN membership.

It is also interesting to note, in respect to NGO-UN relations, that the newly organized WHO initiative on aging focuses on the cross-cultural incidence and manifestations of senile dementia. This focus inevitably brings in psychosocial components and the care of the elderly mentally ill is an important issue for WFMH. WHO's essentially medical emphasis in this regard, though, contrasts with our own primary interest in the maintenance of optimal function and full engagement with life and the community during normal aging.

In the interest of time I will not extend the list of our current projects but note that among the issues for which we have acted as consultants, sponsored conferences, and produced publications are the problems of minority groups; migrants and refugees; people reared in communities without adequate educational and health services; and populations subjected to rapid urbanization, unemployment and illiteracy.

Our next World Congress for Mental Health will be held in this city, Washington, D.C., July 22-28, 1983 under the Honorary Chairmanship of former Governor and Ambassador, W. Averell Harriman. The host organization will be the National Mental Health Association

and the co-hosts will be the American Psychological and Psychiatric Associations. The overall theme will be "Personal and Social Responsibility in the Search for Mental Health." Sub-themes dealt with in morning plenary sessions and afternoon workshops will include health promotion, violence, coping with stress, community responsibility, and population issues. At that time we will celebrate the 75th anniversary of Clifford Beers' founding of the mental health movement, and the more than half century since the first international mental health congress.

We expect approximately 1,500 people from about 40 countries. They will be eager to meet you and know you. I invite your participation.